

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019534

STATE FILE NUMBER

Registration District No. 8 Primary Registration District No. 4565 Registrar's No. 51

FILED JUN 5 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0281
2 02812
3
4 0
5 1
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7 0
8 2
9 4200
10
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12 90-0
13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Crawford</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sullivan</u>		Length of stay in: 1b <u>12 Years</u>	c. CITY OR TOWN <u>Sullivan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>550 B S. Mansion</u>			d. STREET ADDRESS (If outside, give location) <u>550 B. S. Mansion</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Garfield Campbell</u>			4. DATE OF DEATH Month Day Year <u>May 30, 1963</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married: <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/1883</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Sullivan, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Isaac Campbell</u>		13b. MOTHER'S MAIDEN NAME <u>Marinda Pratt</u>		14. NAME OF HUSBAND OR WIFE <u>Orpha Cain</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>			16. SOCIAL SECURITY NO.	17. INFORMANT Address: <u>Orpha Campbell, Sullivan, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause and time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure due to Arteriosclerosis of Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Yes.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>5:00 P</u> to <u>1963</u> and last saw her/him alive on <u>May 25, 1963</u> . Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John J. Jeter, M.D.</u>			22b. ADDRESS <u>Sullivan, Mo.</u>		22c. DATE SIGNED <u>5/31/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/1/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sullivan, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>H.M. Eaton, Sullivan, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5-31-1963</u>	26. REGISTRAR'S SIGNATURE <u>William Cowan</u>		

JUN 1 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harrison W. Eaton

Licensed Embalmer No. 5066

P. O. Address Shelton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.